BHSF Form 148
Rev. 12/08
Prior Issue Obsolete

NOTIFICATION OF ADMISSION, STATUS CHANGE, OR DISCHARGE FOR FACILITY CARE

Provider Name and Address:		Parish:
Telephone #:	Fax #:	Provider #:

I. Applicant/Recipient Information

Name:		SSN:
Medicare #:	Medicaid #:	DOB:
Sex ☐M ☐F	Marital Status ☐Single ☐Married ☐Widow ☐Divorced/Separated	Parish/County:
Address:		Telephone:
Insurance Company Name:		Policy #:
Is applicant receiving Waiver services? ☐Yes ☐No *If yes, family should notify Waiver case manager of admission to facility.*		
Contact Person:		Relationship:
Home Phone:	Cell Phone:	Daytime Phone:
Address:		E-mail:

Note: If Section III is used when the person leaves the facility, use Section III when they return. If Section IV is used when the person leaves the facility, use Section II when they return. Use Section III instead of Section IV when applicable.

II. Admission Information

A. Date of Admission:	Is this the first time being admitted to a Nursing facility? ☐Yes ☐No
B. Source of admission (Section V):_____ Has the applicant been admitted to an acute care setting in the last 30 days? ☐Yes ☐No	
C. Intended payment source (Section VI):	D. Medicaid Co-Pay date (if applicable):

Note: For Section III, A-C, send form 148 to the Medicaid Local Office (LO) only. For D-E, send form to the LO and the Office of Aging and Adult Services (OAAS) or the Office for Citizens with Development Disabilities (OCDD). For F, send form to LO and OCDD.

III. Status Change

A. ☐ Hospital Leave ☐ Home Leave	☐ Medicaid ☐ Medicare billing stopped on:
B. Return from ☐ hospital leave ☐ home leave	Date of Return: **(Note: Also complete box C or D)**
C. Resumed billing to (section VI):	Resume billing date:
D. Change payment source from (SectionVI) _____to_____ Effective date of change: _____ Medicaid Co-Pay date (if applicable): _____ If this is a request for a change from private pay to Medicaid status, what was the original date of admission?_____	
E. Application for extension of medical eligibility from (dates) _____ to _____	
F. _____ Agency custody ends_____(date). Applying for Medicaid effective:_____(date)	

IV. Transfer, Discharge, or Notice of Death

A. Transfer to (Section V):	Transfer Date:
B. Discharge to (Section V):	Discharge Date:
C. Do you anticipate that he/she will return to your facility? ☐Yes ☐No	Date of Death:

V. Places - Specify name & address

Own home	Friend's home	Psychiatric hospital/unit	An ICF-DD	A residential program or group home for mentally ill
Apartment	Nursing Facility	Rehabilitation hospital	Hospice	
Family member's home	General hospital	A Medicare distinct unit	Incarceration	Other (specify)

VI. Payment Sources

Medicaid only	TDC Medicaid	Medicare only (insurance or private co-pay)	Medicare with Medicaid Co-Pay
VA contract (indicate how many months)		Workman's Compensation	Private Pay (i.e. LTC insurance, personal funds)
NRTP Medicaid (specify): **A**. Complex **B**. Rehabilitation		ID Medicaid (specify): **A**. AIDS **B**. TB **C**. MRSA **D.** Other (specify)	
Hospice (specify): **A**. Medicare only, private pay or Medicare/insurance **B**. Medicare with Medicaid for other expenses **C**. Medicaid only			
Other (i.e. OCS Agency- specify)			

Facility Representative _____ **Date** _____